REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Officer** **East Lancashire Healthcare NHS Trust** **Trust Headquarters** **The Royal Blackburn Hospital** **Haslingden Road** **Blackburn BB2 3HH**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 10th November 2015 I commenced an Investigation into the death of Euphemia Lumsden Aldred aged 83 years. The Investigation concluded at the end of the Inquest which was heard on the 16th February 2016. The conclusion of the Inquest was that Euphemia Aldred had suffered fractures to her left leg and ankle, had been treated conservatively in a plaster cast and that following discharge from hospital she was no longer prescribed low molecular weight heparin and she developed a pulmonary embolism and died.
4	**CIRCUMSTANCES OF THE DEATH** On the 26th September 2015 Euphemia Aldred fell in the lounge at her home address and sustained fractures to her left leg and ankle. She was admitted to the Royal Blackburn Hospital where those fractures were treated conservatively in a plaster cast. During her stay in hospital she was prescribed low molecular weight heparin but following discharge was no longer prescribed and subsequently developed a deep vein thrombosis which led to a pulmonary embolism.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed that the East Lancashire Hospitals Trust Policy Document: Venous Thrombo-Embolism (VTE) (non Obstetric) Part I Prophylaxis, Part II Management of VTE V1.4 October 2015 did not comply with the NICE Guidance on Venous Thrombo-embolism in Adults: Reducing the Risk in Hospital: GG92 January 2010.

	matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the **MATTER OF CONCERN** is as follows: - 1.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action in terms of reviewing the Trust Policy.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th April 2016. I, the Coroner, may extend this period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following interested person, namely: [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**18 February 2016** **Signed by:** .... **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**